



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ALLIED MEDICAL CENTERS

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-11-2369-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

MARCH 15, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Attached is a copy of the Pre-Authorization. Please note the start and end date. Our charges are well within the pre-auth period."

Amount in Dispute: \$280.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor obtained preauthorization for physical therapy from Texas Mutual on 9/23/10...Texas Mutual denied payment of codes 97110, 97112, and 97140 billed 10/25/10 for the following reason...Per mutual agreement with LEYLA, preauthorization is given for Physical Therapy 1 x Wk x 3 Wks, per Dr. HICKS to be done at ALLIED MEDICAL CENTERS between 9/23/10-10/23/10...limited to a SINGLE SESSION PER DAY...and that session is limited to 45 minutes to 1 hour duration, no more than 4 CPT codes (97 codes) per session and no more than 45 minutes of cumulative timed codes...The disputed date occurs outside the term of the authorization 10/23/10. The requestor has provided no mitigating circumstance to overcome the mutually agreed upon terms nor has the requestor offered up any attempts to extend the term of the authorization. In effect the requestor wants to retrospectively change a prospective agreement. For these reasons Texas Mutual argues no payment is due."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 25, 2010	CPT Code 97110-GP (x3) Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	\$168.00	\$0.00
	CPT Code 97112-GP Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	\$56.00	\$0.00
	CPT Code 97140-GP Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	\$56.00	\$0.00

TOTAL		\$280.00	\$0.00
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FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective May 25, 2008, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600, effective May 2, 2006, requires preauthorization for specific treatments and services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-197-Precertification/authorization/notification absent.
 - 930-Pre-authorization required, reimbursement denied.
 - 891-No additional payment after reconsideration.
 - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Does a preauthorization issue exist? Is the requestor entitled to reimbursement?

Findings

According to the explanation of benefits, the respondent denied reimbursement for the disputed physical therapy services, CPT codes 97110-GP, 97112-GP and 97140-GP, based upon a lack of preauthorization.

28 Texas Administrative Code §134.600(p)(5), requires preauthorization for "physical and occupational therapy services."

The requestor contends that preauthorization was obtained and payment is due. In support of their position the requestor submitted a copy of a preauthorization report dated September 23, 2010. This report indicates that the requestor obtained preauthorization approval for "Physical Therapy 1 x Wk x 3 Wks...between 9/23/10-10/23/10...limited to a SINGLE SESSION PER DAY, FOR THE COMPENSABLE INJURY...limited to 45 minutes to 1 hour duration, no more than 4 CPT codes (97 codes) per session and no more than 45 minutes of cumulative timed codes."

The respondent argues that a preauthorization issue exists because the requestor exceeded the number of units approved and that the disputed date occurs outside the term of the authorization; therefore, no reimbursement is due.

28 Texas Administrative Code §134.600(l)(1)(2) states "The carrier shall not withdraw a preauthorization or concurrent review approval once issued. The approval shall include:

- (1) the specific health care;
- (2) the approved number of health care treatments and specific period of time to complete the treatments."

A review of the submitted medical bill and Table of Disputed Services finds that the requestor billed CPT codes 97110 (X3), 97112 (X1) and 97140 (X1), that are timed procedures. Per CPT code descriptor, these time procedures are billed at 15 minute increments. Therefore, based upon the medical bill, the requestor billed for 5 units, which equal 75 minutes. Based upon the medical bill, the requestor exceeded the 45 minute time limit that was preauthorized on September 23, 2010. Furthermore, the disputed date of service was outside the specific period outlined in the preauthorization report. Therefore, a preauthorization issue does exist in this dispute. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	04/30/2014 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.